TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Anesthesia Alliance of Dallas

Respondent Name
Farmington Casualty Co

MFDR Tracking Number
M4-16-1316-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the attached MDR request and determine payment is due to the provider for this service, as the carrier acknowledged receipt of the claim before the 95 day deadline which was 11/02/2015."

Amount in Dispute: $671.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing received by the Carrier was dated 11-05-2015 and received electronically on 11-13-2015. Per Rule 102.4(h), documents sent electronically are deemed sent on the date received. The date received was 106 days after the date of service. As the billing received by the Carrier was not timely submitted within 95 days of the date of service, the Carrier properly denied reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2015	01480	$671.03	$670.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.230 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) states in pertinent part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Review of the submitted information finds:

   - Availity report generated on 12/2/2015 that shows;
     - Source/Payer Accepted
     - Date / October 8, 2015
     - Description / Payer acknowledge receipt of the claim

   The carrier states in their response, "the Carrier did receive the billing electronically on 11-13-2015 through their e-billing vendor. This billing, however, was dated 11-5-2015, and does not appear on the claim history submitted by the Provider."

   The Division found insufficient evidence to support the respondents' statement as only the previously mentioned Availity report was found within the documentation submitted with this dispute. This report does state the claim was acknowledged by the correct carrier. Therefore, the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.230 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The allowable for the service in dispute is calculated as follows:

Allowable Base	Time Units reported on CMS 1500	Total	DWC Conversion Factor	Allowable
Code 01480 = 3	134 ÷ 15 = 8.93 units	3 + 8.93= 11.93	11.93 x 56.2 = $670.46	$670.46

3. The total allowable for the service in dispute is $670.46. The carrier previously paid "0.00." The remaining balance of $670.46 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $670.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $670.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.